The Face of Women's Health 65 and Over
November 7, 2002
First Annual Conference
Rhode Island Department of Health
Office of Women's Health

Conference Summary

Thank You

In the evaluations, participants rated the conference a success. For this, there are many people to thank.

The Conference Planning Committee members: Annemarie Beardsworth, Lisa Billington, Rebecca Boss, Melissa Campbell, Donna Cone, Regina Connor, Joyce Dolbec, Helen Drew, Carol Hall-Walker, Andrea Hopkins, Jane Hudson, Marjorie Keefe-Canetti, Nancy Libby Fisher, Dede McGuire, Latoya Moseley, Barbara Peters, and Barbara Roberts, MD.

Conference speakers, panelists facilitators, recorders and moderator: Annlouise Assaf, PhD, Rebecca Boss, Melissa Campbell, Donna Cone, Kristen Cyr, Joyce Dolbec, Felice Freyer, Jana E. Hesser, PhD, Churk Hinman, Wanda Jones, Dr. PH, Cheryl LeClair, Nancy Libby Fisher, Sharon Marable, MD, MPH, Kate McCarthy-Barnett, Patti Melaragno, Barbara Morse, Patricia A. Nolan, MD, MPH, Barbara Roberts, MD, Laurie Robinson, Nancy Sutton, and Luisa Valencia

The exhibitors: the Rhode Island Department of Health Adult Immunization and Office of Women's Health, American Cancer Society, Assistive Technologies Partnership, Care New England, CODAC, Department of Elderly Affairs, Office on Women's Health Region I, Rhode Island Breast Cancer Coalition, Rhode Island Quality Partners, and the Women's Cardiac Center at Miriam Hospital
Thank you also to the participants themselves who have given us the benefit of their feedback and input, which is included in this report.

All conferences require a behind the scenes crew of individuals whose work is largely unnoticed. I want to thank the following for their important roles: MHARC for handling the registration payments, Carla Lundquist and Victoria Sorel for their administrative support, and Sharon Marable, MD, MPH, Medical Director for the Office of Women's Health.

Nancy Libby Fisher
Coordinator
Office of Women's Health
Rhode Island Department of Health

Table of Contents

I. Welcoming Remarks by Patricia A. Nolan, MD, MPH
Director, Rhode Island Department of Health
The Face of Women's Health 65 and Over
Thursday, November 7, 2002

Welcome to the first annual conference of the Office of Women's Health.

The Office of Women's Health was created a year ago to coordinate state-wide efforts to assess the health needs and enhance the health status of women. It integrates and oversees health programs, services, and resources that benefit women's health throughout the state, and is responsible for researching best practices, collecting and analyzing data, developing plans and policies, and providing technical assistance to programs serving women's health needs.

For generations, women's health has been thought of primarily in terms of reproductive health. Only recently has there been general recognition that in addition to health issues unique in women, there are also conditions that are more common in women, are more serious in women, or have causes, manifestations, risk factors, outcomes or interventions that are different in women than in men.

Through data comparisons, we not only have greater knowledge about how Rhode Island women compare with women nationally, and with various women populations in our state, but also how Rhode Island women compare to Rhode Island men. Recognizing gender differences is also important to identify the higher health risks for Rhode Island men.

This conference reflects the intent of the Office of Women's Health to address women's health issues at various points in their lives, and to recognize that health and well-being require more than a "body parts" approach.

The Department's Office on Women's Health works closely with an Advisory Committee, which provides leadership in setting statewide priorities and recommending policies. The Advisory Committee membership is comprised of individuals across Rhode Island representing wide-ranging personal and professional perspectives as well as diverse ages, abilities, racial and ethnic groups. The priorities they have identified are cardiovascular disease, domestic violence, and access issues, and they are also concerned about teen pregnancies. Would members of the Advisory Committee who are present, please raise your hands.

Thank you for coming. I hope you enjoy the conference.

II. Remarks by Wanda K. Jones, Dr.P.H.
Deputy Assistant Secretary for Health (Women's Health)
and Director, Office on Women's Health
U.S. Department of Health and Human Services

"National Health Trends for Women 65 and Over"
Thursday, November 7, 2002 (8:45-9:45 AM)

INTRODUCTION

Thank you for inviting me to speak to you about older women's health on the national level. And thank you for recognizing the importance of gathering together health professionals, including social workers, counselors, and nurses who work on the grassroots level with individuals in their community as well as scientists, academicians, and members of the media.

1. OWH MISSION

The primary mission of the Office on Women's Health is to improve the health and well-being of U.S. women across their lifespan. We coordinate women's health programs with all the federal agencies and offices within the Department for the purpose of improving women's health. We promote health education and disease prevention, and we lead the efforts of federal agencies and their partners to eliminate health disparities.

2. GROWING OLD AND GROWING DIVERSITY

Before we talk about the health of the population we're focusing on today, women over 65, let's talk about two related demographic trends that are changing all of America.

We are experiencing a phenomenon that some analysts have called the "graying," or aging of America because of the size of the baby boom generation. Because women outlive men, we are becoming a nation that has many more older women than older men. Roughly 20 million *women* in the United States are now over the age of 65 (and 15 million men). By the year 2030, the number of American women over the age of 65 is expected to double, to 40 million. One in four American women will be over the age of 65. The number of women living past age 85 is expected to triple. Astonishingly, more than 7 million women will be in this age group, compared to 4 million men.

The face of the American population is also changing. By the year 2030, 1 in 5 American women will be of Hispanic heritage, 1 in 8 will be African American, 1 in 11 will be Asian, and 1 in 100 will be American Indian or Alaska Native. In fact, by 2050, non-Hispanic white women will represent barely one-half of the adult female population in America. Clearly, this century will bring about a redefinition of the concept of "majority." In turn, how we think and what we all do to improve the health of women will have to become more and more inclusive of all racial and ethnic groups.

3. THE HEALTH OF VULNERABLE POPULATIONS

As you know, we are still faced with striking disparities in health care in this country: between Caucasians and racial/ethnic minorities; between men and women; between urban and rural residents; between those with health insurance and those without; between those who can afford health care and those living in poverty; and between states (for example, between Rhode Island and West Virginia). You will hear specific health data about the State of Rhode Island right after the morning break.

And it is the practicing health professional who interacts with some of the many men, women, and children who are the most at-risk: older residents, minority populations, the poor, the disabled, those with chronic conditions, and those who live in unsafe environments.

Of course, older women are included in each of these vulnerable populations.

4. AGING: AN OVERVIEW

I'll continue my remarks by giving you an overview of the national health status of the women we are focusing on today: women over the age of 65.

First, more than 40 million women in the United States are currently postmenopausal. They may well live almost one-third of their lives beyond menopause. That number is expected to increase to 60 million within the next 25 years.

Second, women's average life expectancy used to equal men's. But at almost 80 years, it now surpasses men's life expectancy (73.9 years) by roughly 6 years.

Third, despite the fact that women are living longer, they are not necessarily living healthier. The major killers of women have shifted from infectious diseases and maternal mortality to chronic diseases such as heart disease, cancer, stroke, Alzheimer's, and diabetes. But to be honest, heart disease was a #1 killer a century ago, too. It's just that most of the rest of the top 10 were infectious diseases and the total number of deaths they caused was greater than the number of deaths from cardiovascular disease. Attacking—curing or preventing— infectious diseases alone has allowed people to live longer, and so now we see chronic diseases emerge as the major killers.

Cardiovascular Disease and Stroke

Heart disease is the leading cause of death among all women, including older women, in the United States. Strokes and other cerebrovascular diseases are the third leading cause of death in older women. Despite these striking statistics, many women do not know the risk factors for these diseases.

Physicians and other health care providers are often unaware of how women present symptoms of these diseases. They may ignore the symptoms of heart disease in women or fail to recognize the unique symptoms women display. Once diagnosed with heart disease or a stroke, women are treated less aggressively than men. Women who have heart attacks are more than **twice** as likely as men to die from them within the first year. Educating ourselves—health professionals—and the general public about this issue is an important step in improving women's outcomes from heart disease.

Lung Cancer and Smoking

Smoking is the single most preventable cause of death and disease in the United States. Smoking doubles the risk of getting heart disease. Women who smoke have more heart attacks, cancers, oral health problems, and lung conditions.
In terms of smoking, men are doing better than women, mostly because fewer men now smoke. Male/female smoking rates are now about equal. As of 50 years ago, roughly 50–70 percent of men smoked. Many are dead now, and the gains in replacement smokers came among women, especially in the 1960s and 1970s. And we're now seeing that outcome among women, as deaths from lung cancer outnumber deaths from breast cancer (and this has been true since 1987). In 1999, about 165,000 women died prematurely from smoking-related diseases, like cancer and heart disease.

Quitting results in immediate health benefits for both light and heavy smokers of all ages, including improvements in breathing and circulation. When smokers quit, their lungs begin to heal and their risk of lung disease drops. The excess risk of coronary heart disease is substantially reduced after one or two years of quitting smoking, which is particularly important for older women. The increased risk for stroke associated with smoking is reversible after quitting smoking. Smoking cessation also improves quality of life and physical functioning.

Breast Cancer

The second leading cause of cancer death among all American women is breast cancer. Breast health is an important part of health care for older women because the risk for breast cancer increases with age: 80 percent of women with breast cancer are over age 50. Women who complete menopause after age 55, who have a history of breast cancer in the family, who never have had children, who had a first child after age 30, or who began menstruation before age 12 are also at increased risk of breast cancer. Heavy alcohol consumption and obesity have also been shown to increase the risk of breast cancer.

The lifetime probability of developing breast cancer remains approximately 1 in 8. For most American women, the mortality rate has steadily declined. But for older African American women—those 75 years of age and above—the mortality rate has increased since 1990. We do not know all the factors that contribute to this striking difference. But we do know one reason: African American women tend to get a diagnosis of breast cancer in the later stages of the disease when survival rates are lower. But there may also be biological factors we have yet to identify.

Osteoporosis

Although the roots of osteoporosis stretch across the lifespan, its consequences are predominantly seen at older ages. Overall, approximately 8 million American women and 2 million men have osteoporosis. Women are four times more likely than men to develop osteoporosis because of the loss of estrogen at menopause. (Estrogen blocks or slows down bone loss.) Over half of all women over the age of 65 have osteopenia or
osteoporosis. Even though osteoporosis is often thought of as a disease that only affects older people, it *can* strike at any age.

Osteoporosis leads to 1.5 million fractures, or breaks, per year, mostly in the hip, spine and wrist, and costs an estimated $14 billion annually. One in two women over the age of 50 will suffer an osteoporosis-related fracture.

Exercise is important for preventing this disease and for decreasing the risk of fractures and falls for women diagnosed with osteoporosis. Many women don't know they have osteoporosis until after they have a fracture. Early bone density screenings can help identify women with osteopenia or osteoporosis, so they can receive the necessary medical treatment.

Mental Health

We must also address some stigmatized conditions that impact the lives and health of older women, but are too often left out of discussions of health. These issues are mental health and violence against women.

Mental health problems in older women often go unrecognized, since they are often expressed as physical symptoms such as sleeplessness and loss of appetite, weight, or memory. Some mental illnesses such as depression and anxiety disorders are more common in women than men. Yet research has not focused on the mental disorders of older women.

The World Health Organization has stated that mental disorders, including major depression, are a prominent cause of disability and death worldwide. Depression affects twice as many women as men. We need to look to the situations facing women, as well as examine the biological causes and appropriate treatment for women with major depression.

As I've said, women constitute the largest proportion of the elderly population in this country. And women suffer from Alzheimer's disease—the most common form of dementia—more frequently than do men. Alzheimer's disease is the most common cause of dementia in older people. Dementia is a brain disorder that makes it hard for a person to carry out normal daily activities. Symptoms of dementia include changes in memory, personality, and behavior.

Violence Against Women

Violence against women of all ages is a *health* issue, not just a social problem or a criminal justice issue. It affects women across the lifespan, ranging from their own physical or sexual abuse as children, to assault and violence perpetrated by a woman's partner, to rape, to elder abuse. Domestic abuse is the leading cause of injury to women in the United States. This is another area in which we must not remain silent. Violence against women crosses all boundaries: age, socioeconomic status, race, ethnicity, geographic area, and educational levels.

As the elderly population grows, so do their needs for assistance with the daily activities of living such as eating, bathing, and dressing. Unfortunately, the incidence of elder abuse is also growing as the elder population grows. Most victims of elder abuse are older women who have chronic illnesses or disabilities.

Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. There are three basic categories of elder abuse: (1) domestic elder abuse; (2) institutional elder abuse; and (3) self-neglect or self-abuse. Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly.

Between 1986 and 1996, reported cases of elder abuse increased by 150 percent. Every year thousands of elderly Americans are abused by a caregiver. More than two-thirds of elder abuse perpetrators are family members of the victims, typically serving in a caregiving role.

Urinary Incontinence

Urinary incontinence, or loss of bladder control, causes disability and dependency in a large number of American women, particularly as they age. Incontinence can be temporary, and it may be caused by an underlying medical condition such as diabetes or obesity.

More than 13 million Americans experience loss of bladder control. However, women suffer from incontinence twice as often as men do. Both women and men can have trouble with bladder control from neurological (nerve) injury, birth defects, strokes, multiple sclerosis (MS), and physical problems associated with aging.

Older women have more bladder control problems than younger women do. The loss of bladder control, however, is not something that has to happen as you grow older. It can be treated and often cured, regardless of the age of the woman. However, many women are too embarrassed by their incontinence to talk to their health care provider about possible treatment options. The majority of women with incontinence can be cured or improved; yet only half of these women seek professional help. We have to do a better job of helping these women get the help they need.

5. WOMEN WITH DISABILITIES

Disability rates for women (and men) increase as we age, a fact that is particularly important since women live longer than men do. And the population of older Americans is swelling as the baby boomers age. At present, 28 million American women are living with disabilities. Various diseases and conditions produce some form of disability, and several of them disproportionately affect women.

However, disease and disability are *not* inevitable with age. OWH is encouraging older women to practice healthy behaviors and to take steps to prevent the complications of diseases. And we do have good news about healthy aging: Rates of disability among the elderly are decreasing. Studies find that, even with some limitations in activity, many elderly people still pursue happy and satisfying lives.

However, America's ever-increasing rates of obesity, diabetes, and sedentary lifestyle are of particular concern. Older women *can* live healthier through better nutrition, maintaining a healthy weight, getting regular exercise, and having social support networks. Those of us who hope to join the ranks of healthy older women must act now to ensure that future.

Thank you.

IV. Remarks by Laurie Robinson
Region I Office on Women's Health
U.S. Department of Health & Human Services

"Using Data to Affect Policy"
The Face of Women's Health 65 and Over
Thursday, November 7, 2002

" Everything is Data, but data isn't everything" Feminist Dictionary 1985

"Facts-all facts, explain and confirm each other. They are only partially true until you link them together." Violla Gibbs

So that is the work we face when we attempt to have data inform and affect policy development. We have to link the facts together to create a picture, which allows us to decide what directions to pursue in policy development.

I would encourage us to think about this work from a "Gender-Based Analysis" perspective, which means:

- Assess the differential impact of policies, programs, and legislation on men and women.
- Compare how and why women and men are affected by different policy issues
- Acknowledge that different treatment may be required to assure sameness of desired results.

(This same sort of analysis should apply when looking at race, ethnicity, etc.)

I want to share two examples, one national and one regional, of how data is being used to have an impact on policy, which relates to some of what has been previously presented this morning.

The first is the national women's health report card which is entitled: "Making the Grade on Women's Health: A National and State By State Report Card". This document was developed by the National Women's Law Center, the Lewin Group and FOCUS on Health and Leadership for Women at University of Pennsylvania. The first Report Card was released in August of 2000 and the second in December 2001.

The *Report Card* places a strong focus on women's wellness, defining health as well-being, rather than just the absence of disease. Using this approach, the *Report Card's* authors have included health behaviors, social supports, economic

independence, and safety and health conditions as critical indicators in assessing the status of women's health in each state and nationwide. The *Report Card* also examines statutes, regulations, public policies and government investment in resources that promote women's health. This unique approach to assessing women's health through both health status and policy indicators is being broadly disseminated to federal, state and local agencies and legislators, as well as to advocates who focus on women's health issues.

The *Report Card* is designed to:

- Set forth a systematic and strategic approach to understanding women's health and developing public policy to improve women's health in the United States. The *Report Card* also offers criteria that policymakers and advocates can use to develop priorities and benchmarks to improve women's health.
- Use a new and more comprehensive framework – that of "well-being" – in defining women's health. This framework is a positive departure from the traditional model of women's health which focuses on disease.
- Provide a standard approach to assessing women's health, and provide information on public policy at the federal and state levels. The *Report Card* is also designed to address the information needs of many varied audiences, who together can improve women's health."

It explores 32 health status indicators and 32 health policy indicators, giving the nation an overall grade of "Unsatisfactory." Some of the findings are that:

- Too many women lack health insurance coverage, and many women have inadequate insurance coverage. Nationally, nearly one in seven women (14 percent) does not have health insurance.
- The states and the nation have not done enough to address many women's lack of access to health care and to health care providers. Nearly one in ten Americans (9.6 percent) lives in an area where there are few or no health care providers.
- The states and the nation have not focused enough attention on preventive measures, such as smoking cessation, nutrition, physical activity and screening for diseases and conditions.
- No state has required private insurers to fully cover smoking cessation programs.
- Neither the nation nor the states have paid sufficient attention to reproductive health, mental health, or violence against women. Women's health has suffered as a result.

- Only four states require that insurance companies cover mental health disorders on the same basis as physical disorders.
- Only four states require health care protocols, training and screening for and about domestic violence and sexual assault, and prohibit insurance discrimination against victims of domestic violence.
- Federal and state health policies do not address the health needs and priorities of women in racial or ethnic minorities, lesbians and low-income women.

(Above from NWLC Website)

The New England Region has done well in the Report Card rankings with four of our states in the top 10(MA-2nd, CT-3rd, VT-4th, NH-7th) and all of our states in the top 20. Rhode Island was noted as being one of the most improved states in this year's report, going from 24th in 2000 to 19th in 2001.

The Women's Health Campaign in Maine highlighted its lower Report Card ranking compared to the other New England states and most particularly its neighbors of New Hampshire and Vermont to promote their strategic plan for women's health and to advocate for more funding for improving the health of women.

What I find unique in the Report Card's approach is the 32 policy indicators. The authors of the document have looked at what policies work to promote health for women and have ranked the states on these policies in the same manner they have on the health status indicators. Some of the Report Card policy indicators that relate to older women's health are:

- Does the state provide health care coverage for low income adults not otherwise eligible for publicly funded health insurance?
- Is support for family and medical leave available?
- How well does the state assist women in getting access to prescription drugs?
- Has the state enacted mental health parity legislation?
- Does the state require private insurers to cover colorectal cancer screening?

The policy indicator section includes indicators on economics and other environmental issues that can affect health outcomes such as:

- Does the state have effective gun control laws?
- Does the state have effective policies to increase women's economic security?

I recommend that you take a look at this list of policies as you consider what policy priorities to discuss in your upcoming groups.

2. The second Regional example of policy work is NECON (New England Coalition for Health Promotion and Disease Prevention.) This coalition which began in the mid 80's convenes a conference and working groups that make recommendations to the New England Governors Association and the New England Health Officers, such as Dr. Nolan about important health promotion and prevention issues for the region.

There are NECON Task Forces on Cancer, Mental Health, Racial and Ethnic Disparities, CVD, HIV/AIDS, Women's Health, and a new one on Obesity.
In 1997, the Women's Health Task Force, which had members from the state health departments, academics, the health care industry, providers, etc. convened to make recommendations. The policy recommendations were meant to foster improvement of women's health across the lifespan in the New England states. They wanted to balance the historically reproductive and child bearing perspective on women's health with a more holistic, prevention focused, lifespan approach. The Task Force looked at various health indicators for women in the region, at research and also at inequities in health status for various populations of women and came up with the following recommendations:

- Recommend and support a base infrastructure for women's health in each New England State's public health agency that promotes primary prevention and a coordinated comprehensive approach to health across the lifespan.
- Focus attention in the public, private and academic sectors on critical women's health issues across the lifespan, which can be impacted by prevention strategies and systems interventions:
- Develop a policy statement prioritizing improvement in health status for female adolescents and elderly women.
- Identify outcome/health indicators for adolescent and elderly women that if achieved will reflect improvement in the health of adolescent and elderly women in New England.
- Advocate for shared data monitoring and information dissemination among public, private and academic sectors.
- Promote improvement in the identified indicators through the development of public/private strategies, partnerships and policies.

The Women's Health Task Force developed indicators on adolescent and elder women's health, the less focused on parts of the lifespan, to monitor across the region to improve health status for women. Elder Women's Health indicators are:

1. Health Insurance
    % of women age 60 and over who are covered by any insurance.
    % of women who use their Medicare preventive benefits.
2. % of women age 60 and over receiving immunizations
    % receiving annual flu shot
    % receiving pneumonia vaccination.
3. % of women age 60 and over who experience falls resulting in hospitalization.
4. % of women age 60 and over with depression.
5. % of women age 60 and over with an acute myocardial infarction

Currently, the Regional Office is funding a project to collect baseline data on the adolescent and elder women's health indicators. Jacqueline Fields, a senior researcher from the Wellesley Center is in the audience today and is completing this project, which will be shared with the states to assist in their analysis and planning for improving women's health.

Many of the NE states have been engaged in policy and program work relating to the NECON recommendations:

- Maine: Cardiovascular Disease, Elder Women's Indicators, Adolescent Girls Health Plan and Conference
- Vermont: Women and Cardiovascular Disease Conference and a part time position on women's health. Developing data profile.
- New Hampshire: Training for AOA providers and regional agencies in the 5 elder women's health indicator topics. Workshop on Elder Women's Health at Women's Prevention Conference in Concord. Women's Legislative Caucus looking at Women's Health infrastructure.
- Maine and Massachusetts: HRSA funding for Women's Health Infrastructure development…comprehensive approach. Gender analysis in Maine HP 2010 Report.
- Rhode Island: First and only legislatively mandated and funded Office on Women's Health in New England.

Policy work is not restricted to just legislative action, and can involve regulations, budgets, communications, contracting mechanisms, and so on. As you focus on policy recommendations for Rhode Island women, I encourage you to think broadly today, of all the arenas which can have an impact on elder women's health.

In closing, I want to share this quote from Margaret Mead: "A small group of thoughtful people could change the world. Indeed, it the only thing that ever has."

V. Policy Initiatives at the Local Level
Break-out Sessions for Input and Feed-back

GROUP A

Facilitator: Luisa Valencia, BlueCHiP, Coordinated Health Partners, Inc.
Recorder: Melissa Campbell, American Cancer Society

I. Introductions

Agencies represented included: Elderly Housing Department, Genesis Center, Urban League, Portsmouth Housing Authority, URI Senior Nutrition Awareness Project, Hospice Care, Real Estate Preceine, Elizabeth Buffum Chase, RI Primary Care Physicians, Warwick Housing Department, Fruit Hill Day Care Center

II. Discussion

Group members discussed the need for better coordination and networking between Federal, State, and non-profit organizations in order to have greater awareness of the services available to the population's represented. It was felt that within our State there were excellent community based organizations and resources but this information was not always readily available. Improving communications between agencies to avoid fragmentation and promote information sharing also discussed.

The group felt that conferences such as this one helped to provide an awareness of the services and programs available and opportunities to network, brainstorm and identify best practices.

III. Policy Considerations

The following is a broad list of topics that were identified as requiring policy discussion or necessitating further education or awareness at a policy making level.

- Training of medical providers (primary care physicians and specialist) to foster greater understanding of the issues that is facing our older population. Examples included isolation, limited incomes and limited access to nutritious foods and dental care low literacy,
- Mental health education programs for health care providers – for older populations
-Access to healthcare for the undocumented elderly population
-Affordable health insurance for all populations
-Affordable housing for older population
-Access to transportation for older population

-Rural health care
-Elder abuse – developing better screening tools for older population
-Standardized guidelines, regulations and protocols for assisted living facilities, independent care facilities and nursing homes
-Confidentiality – issues and roadblocks created for coordinating and referring between agencies
-Reimbursement for direct care staff, RN's, CNA's needs to be increased in order to retain high quality-trained staff.
-Promote and support increased reimbursement to providers for screenings that are currently not reimbursable through Medicare or Medicaid
-Support programs to address nursing shortages
-Cultural competency rules & regulations
-Promoting best practices

GROUP B

Facilitator: Joyce Dolbec, Office of Women's Health Advisory Committee
Recorder: Rebecca Boss, CODAC

I. Needed
- RIPAE needs to be reformed to new managed care guidelines
- Public funding should be expanded to include broader range of assistive technology
- Reimbursements for lower income seniors to take advantage of alternatives to nursing homes
- QMB and SLMB needs to be addressed at senior centers and senior housing
- Guidelines for these programs need to be changed at federal level ($4,000 cap)
- More outreach to elderly population
- Nutritional needs not being met. Food stamps and Meals on Wheels programs need to be expanded
- Benefits specialists needed – better coordination
- Deep DEA as separate entity
- Access to transportation improved
- Pharmaceutical program – funding for prescriptions
- Encouraging increased accountability of expenditures of health insurance companies

III. Policies Introduced or Advocated for
- Counsel on phone
- Walk ins

- Longevity of staff-consistency
- Personal counseling
- Look into Indiana pharmaceutical reimbursement program – combination of federal and state dollars
- Thundermist Health Center program
- Utilize alternative resources for outreach (supermarkets, libraries, etc.)
- URI medication for the need 1-800# and DEA for specific medications and specific income
- RI Hospital pharmacy program accessed through physicians
- Ask Doctor for samples (limited and not on-going) useful for initial use of a medicine (trial period)
- Long wait for pharmaceutical company assistance
- Misleading advertisements
- Aging 2000 good resource for information – mixed response re: usefulness and lack of awareness re: this resource
- AARP needs to be more active. What is their role?
- Increase awareness of find print and deductibles
- 4 week lead time for RIDES program, limited hours and limited access – become more "consumer friendly"
- Past program for transportation better when decentralized
- Massachusetts has a taxi voucher program for low income seniors
- Knowledge of lifeline for seniors who live alone (no subsidy)
- Increase home care services (long delay) – low pay doesn't attract qualified workers
- Reimbursement needed for education programs to certify home health aides
- Home health aides – need funding to address requirements for employment

GROUP C

Facilitator: Kate McCarthy-Barnett, Ed.D, Office of Women's Health Advisory Committee

Recorder: Nancy Sutton, Rhode Island Department of Health

I. Barriers for Older Women

Transportation
understand and navigate system
cost
supplying services (e.g., home care, lack provider)
prescription coverage
language
denial

information access (linguistics/culture)
misinterpretation and miscommunication and compliance to medical advise
follow-up/continuity of care - how to (e.g., p.a.)
Communication skills of provider
auditory disability NOT recognized by provider
attitude of hcp
accessibility to get follow-up information
Hospice
- confusion with what is available in the system
- coordination of services

Advocacy
lack of family support
respect family support
lack of resources/educational materials and access to these
multi-media access to services and information
networking needed

II. Policy Initiatives (6 - 10 policy initiatives needed)

A. Key areas where we need policy:

1. Organization
2. Partnership/collaboration/consolidation
3. Access
4. Education
5. Advocacy

1. Organization

- Service coordination - underfunded (community based mode)
  Increase funding and legislative support for private, government, municipal
- Coordination and organization within center
- Disseminating and filtering of information
- consolidation of agencies
- consolidation of volunteer groups
- education and communication between agencies and within agencies

2. Partnership/Collaboration/Consolidation

- Networking of agencies to send out same messages
- Use data - action
- interventions to meet goals and objectives
- program collaboration
  - hospitals, pharmacies, social workers

- mutual value
- ♦ Funding/pooled resources
- ♦ basis should recognize goals of task force
  - focused task forces (e.g., to reduce duplication)
- achievement focused

3. Access
- ♦ Transportation - affordable
- ♦ prescriptions - affordable (>65)
- ♦ government intervention with common medications of >65 - cost and availability
- ♦ language appropriate communication
- ♦ all med versus based on body parts
- ♦ categorization of medication
- ♦ disability access
- ♦ educating youth to prevent
- ♦ mental health treatment/services
- ♦ reduce stigmatism of mental health
- ♦ increase knowledge of how to access help
- ♦ increase multi-services delivery center
- ♦ elderly affairs - delivery system
  - links - same services who do not have access to centers
- ♦ specialization of medical care

4. Education
- ♦ Centralized resources (yellow pages, clearinghouse)
- ♦ available and affordable to agencies
- ♦ linguistically and culturally appropriate
- ♦ filtering money to local towns
- ♦ multi-presentation
- ♦ local department of health
- ♦ local grassroots approach to dissemination of educational materials and information
  - linkages between state and local
  - CLAN resource as a public education system for health
  - change perception of elderly (more positive)
- ♦ recognize many do <u>not</u> have access to internet or television
- ♦ alternative formats
- ♦ information bulletin board at designated locations (sr. Centers, malls)
- ♦ get input and buy-in of target population

- voice of elderly needs to be heard
- ongoing updates of information
- better use of funded resources
- waste of funds by little collaboration

5. Advocacy
- elect more women to public service
- partner with women's groups and churches (elderly specific)
- mentor opportunities with the elderly women
- living alone support for health problems
  - structure for - resources
- empower women to be own advocate
- increase economic self-sufficiency
- increase involvement of legislatures
- increase funding to support advocacy
- increase involvement of women in election process
- increase lobbying
  - skills and techniques
  - resources, materials, and information needed
  - testifying
- collaboration of agencies to strengthen advocacy

B. Key Policies

1. Accountability of research and data, validity of data, shared data, access to data, translate data
2. Coordination and collaboration of resources and services
- all information - translate in multi- formats and languages . . . Access of information at multi-format
- coordination of services and efforts
- access what is going on
- increase efficiency
- identify task force to look at services offered and propose coordination
- Regionalization - help local towns and cities assess resources and opportunities for collaboration
- vertical integration and horizontal integration of services
3. Budget issues
- agencies and organizations need access to the information and decision-makers need input at all levels
- identify women

GROUP D

Facilitator: Barbara Roberts, MD, Women's Cardiac Center at Miriam Hospital
Recorder: Cheryl LeClair, Rhode Island Department of Health

Barriers

- More coordination among agencies serving elderly women is needed (e.g., Meals on Wheels and Visiting Nurse visiting the same home). Confidentiality restraints create barriers to communication between important players.
- Rhode Island is 47th lowest in nation - reimbursement rate
- Deal with people's diseases; don't look at the whole person and their needs
- Over-controlling of medical care by insurers; doctors getting less money or have to increase number of patients seen every 15 minutes
- More money spent on administration and oversight than on care
- People need to know what to ask their doctor when they get there, but if they take the time to ask questions, the doctor is being pressured to see more people in less time. This is creating a monster – perception is that patients are not getting their needs met and doctors don't feel they have time to address patients' needs
- Safe and lit sidewalks – local level policies to make our communities healthy and improve quality of life
- There is still local opposition against creating bike paths and other recreational outlets
- Safety issues in urban and high crime areas, which prevent people from walking in their own neighborhoods. Previously, the park bench was a great place for older people to walk to, gather and socialize.
- Still need broader definition of health that includes dental health, mental health, etc.
- Transportation is big problem for elderly. Mobility without transportation is still very limited. DEA van is designed for doctor's appointment, not for shopping, visits to hairdressers, etc.
- Prevention gets less money. How can we tap into other resources to maximize resources?
- Reasons for discharge from hospital is not always the same cause for which they were admitted. They're released with a diminished capacity to function (independence). 44% of women are living alone to begin with, so when they are discharged from the hospital it is more difficult for them to maintain independence alone.

- Increased number of supermarkets and pharmacies has decreased the number of local markets and pharmacies, which are easily accessible to the elderly.

Models

1. Good external patient-based models do exist in Rhode Island (i.e., whole person vs. disease-based model) For example, the Fleet/March of Dimes project that looks at pre-maturity.

2. Bike paths, Greenways, etc. interconnected among communities create health and safe opportunities, but have only just begun in this area.
3. Volunteer Seniors Help Seniors model could be adopted to help ease transportation problems, especially in rural areas.
4. Assets Model approach to problem solving in needed for elderly, using the Youth Development for Youth as a model.
5. Benches are a wonderful way to help build community. Teens could build benches for seniors with grant funds.
6. Increased case management is needed for the elderly. New York has a nice model that focuses on helping people stay at home.

VII. The Face of Women's Health 65 and Over
November 7, 2002
Conference Evaluation Results

Evaluation Forms - Two evaluation forms were used.

The primary form provided an opportunity for conference participants to rank (1) seven Conference Objectives, (2) Relationship of Objectives to Overall Conference Purpose, (3) Appropriateness of Physical Facilities, (4) Effectiveness of Presentation Styles of speakers, (5) Knowledge of Presenters, and (6) Effectiveness of Teaching Strategies. Space was provided for Comments, and for Recommendations for future topics, location and scheduling.

The second form was used to supplement the primary form and included very specific questions for the small number of conference participants seeking credit from the National Association of Boards of Examiners of Long Term Care Administrators (NAB).

Rankings

Over 50% (54 individuals) of the 100 conference participants used the evaluation forms to assess the conference.

The following is the number and percentage of participants who ranked whether each of the conference objectives and related items was met, partially met, or not met.

	#	% Met	% Partially Met	%Not Met
Conference Objectives				
1. Learn about National health trends	48	83.3	16.7	
2. Research data on older R.I. women	49	73.5	22.4	4.1
3. Understanding of health care needs	49	69.4	30.6	
4. Identify policy initiatives related to health needs	47	66.0	25.5	7.5
5. Explore policy initiatives on local level	45	60.0	28.9	11.1
6. Local health research on older women	44	79.5	13.6	6.9
7. Strategies for awareness of health resources	43	69.8	20.9	9.3
Relationship of objectives to conference purpose	35	77.8	17.8	5.4
Appropriateness of physical facilities	29	63.0	32.6	4.4

The following is the number and percentage of participants who ranked whether they agreed, were undecided, or disagreed with (1) the effectiveness of the presentation style for each speaker, (2) whether each presenter was knowledgeable, and (3) the effectiveness of teaching strategies. Fox Wetle, a speaker listed on the original evaluation form, was sick and could not attend the conference. Jana Hesser's presentation was expanded to include additional information.

Presentation style effective for content	#	% Agree	% Undecided	% Dis-agree
Wanda Jones, PhD	47	100.0		
Jana Hesser, PhD	46	82.6	17.4	
Laurie Robinson	47	90.0	8.5	1.5
Nancy Libby Fisher	38	82.0	18.4	
Annlouise Assaf, PhD	42	97.6		2.4
Media presenters	24	91.7	8.3	
Presenter was knowledgeable				
Wanda Jones, PhD	45	100.0		
Jana Hesser, PhD	45	88.9	11.1	
Laurie Robinson	44	90.9	9.1	
Nancy Libby Fisher	40	90.0	10.0	
Annlouise Assaf, PhD	41	95.2	2.4	2.4
Media presenters	30	96.8	3.2	
Effectiveness of Teaching Strategies	44	79.5	20.5	

NAB Evaluation

Participants seeking NAB credit were asked to rate six aspects of the conference program using the following scale:
5 = Excellent, as good as I've ever attended
4=Good, meets high standards, would recommend to others
3=Satisfactory, acceptable but not outstanding
2=Poor, having at least one serious deficiency. Would not recommend.
1=Terrible, as bad as I've ever attended.

Three of these forms were completed. The following lists the question and ranking.

Question	Ranking of Each Participant		
Learning objectives and content material	5	5	4
Appropriateness of topic & content to long term care	5	5	4
Usefulness of knowledge/skills acquired	5	4	4
Instructor's knowledge of materials/topic	5	5	4
Instructor's presentational skill	4	5	4
Overall rating	5	5	4

COMMENTS ABOUT CONFERENCE CONTENT

- Very good presenters/very interesting and important and relevant
- I am new to R. I. and would have liked to know what different health organizations do, how we can access their resources, what resources or services they provide, etc. I would like to get all of the great information to the community. More info on how health organizations can collaborate with community organizations. More practical info on how to put this data to work to make a difference in women's health.
- Excellent presenters!
- Excellent program. Great vendors.
- Wonderful conference
- A lot of the material was read from notes, could have been more dynamic
- Have other ethnicity to join in as a quick presenter what it is like to be a woman of other minority – it would be interesting
- Wish there were more power points and supporting handouts.
- Since I like and learn better through written material better than by listening. I would like a written summary of this good meeting (not e-mail).
- Need to use microphones for questions and comments.
- I wish M. Assaf spoke more beyond HRT.
- Need to show what action is being taken
- Jana Hesser's talk was excellent
- Effectiveness of Teaching Strategies – wonderful. More time for conference participant discussion.
- More on hands material not reading from data – more informative. Many women 65 and over are depressed because they have lost their spouses and they are lonely and need sources where to find meaningful activities and events to meet and make new friends. Dr. Hesser's studies were very interesting.
- Particularly why would asthma decrease in women 65 and over? Also, 80% of hospitalizations/women are falls. Are we sure, or is this a matter of screening

and some is really elder abuse or domestic violence? I would like someone to study this further!
- Annlouise Assaf +++++
- Annlouise Assaf Excellent!
- I really enjoyed the conference. The topic could not have been more timely giving the demographics of the state. I would have done a little less data. The brainstorming session was great!
- Annlouise Assaf a little dry.

COMMENTS ABOUT the PHYSICAL FACILITIES
- Poor space/hotel environment.
- Please hold meetings in Providence!! More central for <u>everyone</u>.
- Provide more healthy food: for example, for breakfast offer herbal tea with honey, oatmeal (whole grain) with fresh fruit, granola, whole grain breakfast cereal, yogurt, Rice Dream, soy milk options, whole grain breads, toasted grain breads. For lunch pasta plate is not super-dosed with vinegar, soy hamburgers, salads, vegetarian sandwich options.
- Should have been directional signage at entryway to downstairs
- Room cold
- Room cold after lunch!
- No break out rooms
- Hotel not the greatest
- Room was freezing the entire day

RECOMMENDATIONS FOR FUTURE TOPICS
- Minority Health issues
- 1. Women and HIV/AIDs, 2. Women/Contraception Choices, 3. Women In Prison/Health Issues and Priorities, 4. Adolescent Mothers/what are their long range health outcomes
- Isolation in elderly women – how this affect safety, elder abuse, domestic violence, and screenings for major illness affecting women, including mental illness, cancer, heart disease, colon cancer, breast cancer, etc.
- For future sessions on women's health I would urge you to look at the impact of low income and poverty on women, particularly seniors. This topic is usually targeted at younger women but so many senior women are low-income levels. Another topic could be social services and senior health. So many of us here are from the social services – we don't provide the health care, but we are a key component – and as a group we always want to know how we can better serve our populations.